Mental Hygiene Priority Outcomes Form
Erie County Dept. of Mental Health (70290)
Plan Year: 2014
Certified: John Grieco (6/4/13)

Attachments

Consult the LSP Guidelines for additional guidance on completing this form.

2014 Priority Outcomes

Priority Outcome 1

Prepare for Conversion of Medicaid Fee for Service to Medicaid Managed Care

The changes in the environment related to the Affordable Care Act and New York State's Medicaid reform will result in the move to a managed care environment for behavioral health in 2014. The Erie County Department of Mental Health vision for the Erie County Adult System of Care (SOC) is that providers will be working together using person centered practices in support of recovery, where optimally effective services are available in a timely manner to the emerging populations and where Behavioral Health and Physical Health are integrated. In this system of care, providers are focused on working interdependently to reduce imminent risk for out of community placement or bend the trajectory of risk and to ease transitions by removing barriers to care. The new or evolving Medicaid services will be comprehensive, integrated and capitated. This will involve changes for individual consumers, family members, and service providers. There will be new reimbursement structures which may reduce or eliminate Medicaid add-ons. Clearly, this change is rapid and will occur with or without local design efforts. Erie County's local approach is intended to demonstrate value of the local service system prior to the next managed care Behavioral Health.

Changes are occurring rapidly and there is an urgent need to manage healthcare reform at the local level. There is a short-term opportunity for Erie County, providers, consumers and stakeholders to take advantage of the reform opportunity offered by Health Homes and Medicaid Reform initiatives to demonstrate the value of locally driven systems of care and optimize the positive impact of changes on our local community. A primary goal is to bring together government entities and service organizations to quickly and proactively adapt to changing requirements.

Agencies: OASAS; OMH; OPWDD;
This outcome has been selected as a top priority.

Strategy 1.1

The Erie County Department of Mental Health will engage in dialogue with the Regional Behavioral Health Organization, Health Homes and Managed Care Organizations regarding: * Use of data analystics * Identification of shared expectations, procedures and policies to best serve individuals * Identification of critical metrics * Use of critical metrics to prepare our the system of care and * Improve behavioral health and physical health integration

Metric:
Metrics to monitor progress:
* Meetings with the Regional Behavioral Health Organizations, Health Homes and Managed Care Organizations
* Finalization of necessary data sharing agreement with at least one Managed Care Organization
* Development and evaluation of pilot programs

Agencies: OASAS; OMH; OPWDD;

Strategy 1.2

There is a need to reduce inpatient admissions as well as to increase the amount of time of communtiy tenure.Erie County has worked in partnership on the development of a risk-based, predictive model to explain trajectory of deep-end system penetration. Primary focus is to make the results translatable to professionals so the results can impact administrative, supervisory and direct practices. This model will be incorporated into the daily decision making processes of professionals in the adult system of care. Erie County will use all available data sources to identify individuals and use the integrated SPOA to facilitate access to services for high risk individuals. Available data sources presently incorporated include Medicaid Adjudicated Claims and Salient. This data will be supplemented by and enhanced by other data as our analysis will be ongoing. This will result in an analysis for risk of readmission to hospital based care as well as a trajectory of community tenure. Once identified, we will use evidenced based practices to promote engagement and appropriate quality services. Examples include the developing OMH service models targeted to individuals at their first psychotic break, and emerging peer fidelity practices.

Metric:
1) Implement Algorithym that will Identify risk factors for trajectory of community tenure and risk for inpatient hospitilization
2) Incorporate the utilization of this tool into the daily pracite of the integrated SPOA.
3) Review impact of trajectory tool and modify practice as data suggests.

Agencies: OASAS; OMH;

Priority Outcome 2

Focus on risk mitigation and harm reduction

In this rapidly changing environment, the model of traditional care coordination services will become more short term, episodic, and much of this resource will be tied to Health Homes.

Erie County is committed to a “risk reduction” approach that incorporates the provision of services and supports to the right person, right time, right service, for the right outcome, for the right length of time. Since needs related to behavioral health, physical health, arrests, homelessness, and substance abuse are the critical risk factors to be addressed in attaining overall wellness, the adult system of care will focus reducing imminent risk and/or bending the trajectory of risk by removing barriers to care so that people can receive needed services and supports.

Historically, rehabilitation & recovery have meant long-term support. Per the MRT recommendations, managed care entities should develop robust care coordination activities that include intensive data-driven strategies to identify (and serve) high need consumers e.g. those disengaged from care, those at high risk of suicide, and those with a history of violence. This will also require a robust Utilization Management to assure access to timely community based services. Providers will need to assist consumers to receive ongoing treatment & support through removal of barriers to community-based services both inside and outside of the healthcare system.

Agencies: OASAS; OMH;
This outcome has been selected as a top priority.

Strategy 2.1

Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to enhance continuity of support for people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in stable housing with access to needed supports. CTI works in two main ways: by providing emotional and practical support during the critical time of transition and by strengthening the individual’s long-term ties to services, family, and friends. Ideally, post- discharge assistance is delivered by workers who have established relationships with clients during their institutional stay. The SPOA will assign non-health home eligible individuals to CTI providers in order to focus on imminent risk reduction and/ or bending the trajectory of risk through removal of barriers to wellness that are encountered during transition from any level of care, and fully utilize generic community services for support rather than the healthcare system. In addition, in April of 2013 the Department has initiated a pilot initiative in Children’s Outpatient Mental Health clinic. This pilot at two NYS OMH children’s outpatient clinic utilizes the values and philosophy of CTI by paring a CTI care manager with a clinical therapist. The goal of the initiative is to identify eligible youth with barriers to successful transition from clinic that would benefit from a CTI approach to develop and strength sustainable community resources to address those concerns thereby making a more timely and effective

Metric:
1) CTI Fidelity measures and reporting will be in place
2) Train the trainer model for CTI will be implemented
3) All Adult SPOA non-health home care coordination slots will use CTI
3) Length of stay consistent with CTI 6 month model
4) For Children's clinic CTI pilot:
a) Length of Stay post enrolled in CTI to be consistent with
model of 3 months in clinic and 3 additional months in CTI;

Agencies: OASAS; OMH;

Priority Outcome 3

Expand access to housing, including that which is non-licensed.

Behavioral Health Reform demands timely access to the right services for the right person, at the right time, for the right length of time, for the right outcome. Presently, the ability to quickly access housing in Erie County is limited at best. This prevents individual consumers who are most at risk from being able to access the stabilizing influence of adequate housing in a timely manner. This is borne out by the fact prior to the reform being implemented the waiting list for supported housing services in Erie County is consistently in excess of 100.

Transition to more independent housing is limited and generally occurs after many months and years in the program. This is illustrated by the NYS OMH Residential Programs Indicators Report. The report shows that of those in residence at the end of the report period for the 2011 Calendar Year, the Median Length of Stay was 1155 days, or 3.164 years. Moreover, NYS OASAS Service Need Profile for Erie County shows that only an estimated 35% of the need being met. In order to be responsive to the new paradigm and facilitate timely access, successful transition from supported and supportive housing to independent housing must occur in much swifter time frame than has historically occurred.

Agencies: OASAS; OMH;

Strategy 3.1

Increase access to housing for High risk seriously mentally ill individuals. Through a Request for Proposal, the Erie County Dept of Mental Health will implement a pilot initiative that seeks to have a normative length of stay in supported and/or supportive housing of six (6) month while transitioning to successful independent housing with sustainable community tenure. The service agency will be required to utilize and integrate the best practice of Critical Time Intervention (CTI). CTI has promising literature on achieving transition for those in need of housing within the targeted normative LOS. In close collaboration with the provider and County, the initiative will be rigorously monitored thru the use of data analysis, Quality Improvement and Utilization Management practices. This initiative was implemented in August of 2012 and is now seeing its first consumers transistion to sustainable community housing. While more time and greater numbers are required for proper evaluation a site review suggested promising preliminary outcomes at this admittedly early juncture. Add 30 Suppported Housing beds through NYS OMH funding. Referrals will be made throught the integrated SPOA to assure eligibility and timely access for the target population.

Metric:
1a) The pilot initiative will be implemented and the normative LOS will be six (6) months.

1b) The practice of CTI will be broadened to the agency's supported and/or supportive housing capacity where the Median normative LOS in supported/supportive housing for new consumers will also decrease from pre pilot initiative Median LOS.

1c) NYS OMH supported housing will be at full capacity of 30.

Agencies: OASAS; OMH;

Strategy 3.2

Relocate the Cazenovia Recovery Services New Beginnings Community Residential program and expand its capacity by two or more beds. The primary reason for this relocation is due to issues associated with the physical plant condition of the New Beginnings facility. This 2013 outcome is being continued because of significant siting challenges and barriers creating significant delays.

Metric:
Current program will be relocated and will be expanded by 2 or more beds.

Agency: OASAS;

Priority Outcome 4

Better Integrate Behavioral and Physical Health

According to the New York State Medicaid Redesign Team (MRT) Behavioral Health Reform Work Group:
*People with serious mental illness die 15-25 year earlier on average than average; and,
*The majority of preventable admissions paid for by fee-for-service Medicaid to Article 28 inpatient beds are for people with behavioral health conditions, yet the majority of expenditures for these people are for chronic physical health conditions

The MRT has identified the fragmentation of behavioral health care, and lack of integration/coordination with physical health care as contributing to poor outcomes.

Agencies: OASAS; OMH;
This outcome has been selected as a top priority.

Strategy 4.1

The ECDMH will work cooperatively with stakeholders to accomplish the following: * Work with the Erie County Health Department to increase behavioral healht services co-located or embedded in primary care facilites * Identify opportunites to improve the capacity of care managers to address physical health needs * Work with Managed Care Organizations to improve access to behavioral health services for individuals with serious behavioral health disorders served in the physical health system

Metric:
We are early in this process, and will be taking advantage of opportunites that emerge. Prelimary metrics are:
* increase in mental health clinics co-located in pedicatric practices
* Review of physical health/behavioral health metrics
* Identificaiton of data source

Agencies: OASAS; OMH;

Priority Outcome 5

Better link high risk children & youth to treatment services in the community

According to the New York State Medicaid Redesign Team (MRT) Behavioral Health Reform Work Group, lack of coordination extends well beyond physical health care into the education, child welfare and juvenile justice systems for those under the age of twenty-one. The MRT also identified access to early identification and intervention with children as a core standard. Included in this standard is access to first-level intervention and consultation within seven days.

Currently, in Erie County, there is a lack of access to Mental Health Clinic, and related to this lack of access, the median length of stay is approximately one visit.

Agencies: OASAS; OMH;

Strategy 5.1

To better address issues around engagement of families with children presenting with behavioral difficulties, and perceived lack of access to Mental Health Clinic, Erie County will redeploy some of the current Intensive Case Managers to focus on improving access for children with serious emotional disturbance by using Critical Time Intervention tenets to facilitate transition to licensed clinic programs. As of April 2012 this pilot initiative has been implemented and the steps outlined below accomplished. The first steps in this process will be as follows: *Working with CTI experts in identifying critical practice elements for this CTI modification *Developing practice fidelity standards and reporting *Training ICMs in the CTI model *Defining the target population profile for this initiative *Identifying provider partners, both Targeted Case Management and Clinic

Metric:

1) Reach expected capacity within 7 months of april 2013 implementation (fidelity dictates ramping up capacity in phases)

2) First grouping of children/youth/familes have transition from the clinic with 75% success rate.

3) Expected Lenght of Stay once enrolled with CTI care managment support is normatively

Agencies: OASAS; OMH;

Priority Outcome 6

Assist in expanding housing capacity/placements in integrated settings for dually diagnosed individuals (Developmental and Psychiatric Disabilities) outside of the certified residences.

Agency: OPWDD;

Strategy 6.1

The Erie County Department of Mental Health will provide support and technical assistance to the DDSO – Region 1 (OPWDD) including but not limited to the following: • Discuss housing opportunities/individuals needs with the OPWDD Subcommittee as system reform occurs to include advocacy for reinvestment of local/county funding from group homes to community residences to appropriate State agencies • ECDMH SPOA staff will participate in housing related care management meetings for dually diagnosed individuals who are at risk of homelessness or homeless; Identification and Linkage to services • Provide letters of support per Certificates of Need as identified by the DDSO/housing providers

Metric:
• When requested by the DDSO-Region 1(OPWDD) ECDMH will participate/consult in the development of person centered capitation models via the pilot case studies.

Agency: OPWDD;

Priority Outcome 7

Consistent with the Centers for Medicare and Medicaid Services (CMS) focus on employment, ECDMH will support/participate in the development of a continuum of employment options designed to assist individuals to move toward competitive and community activities.

OPWDD's focus is to develop a full continuum of employment options designed to move individuals toward competitive employment and community activities that are meaningful and productive. The silos of pre-vocational services, supported employment services and day habilitation can be integrated as a fluid entity designed to provide employment opportunities for individuals who choose to pursue employment. (Explanation per the 2012 Interim Report: NYS Office for People with Developmental Disabilities: 2011 - 2015 Statewide Comprehensive Plan)

Agency: OPWDD;

Strategy 7.1

The Erie County Department of Mental Health will support/participate in the development of cross county learning communities to include the following focus areas. • Evaluate data systems that supports employment for individuals with developmental disabilities i.e., New York Employment Services System (NYESS), ACCESS VR • Establish local means to provide community education about perceptions and community integration of people with disabilities to include social marketing efforts • Begin discussions that include the development of vendor networks between the developmental disabilities and mental health systems

Metric:
Possibly modify OPWDD county contracts related to employment per stages of development
• Redistribution of resources when and where appropriate

Set joint meetings to develop outcome measures and quality improvement planning based on data reports from OPWDD contract agencies

Agency: OPWDD;

Priority Outcome 8

Participate in Regional and Local level OPWDD systems meetings to support the implementation of the Developmental Disabilities Individual Support and Care Coordination Organization’s (DISCO).

OPWDD has received responses to the RFA for the development of DISCO's. The OPWDD Subcommittee's standing agenda item will include updates from the DDRO-1 regarding implementation and how reform will be rolled out locally and what the impact on indiviudals and families will be. The OPWDD subcommittee consists of service providers and families who continue to provide feedback and recomemndationsf to address the effects of system reform.

Agency: OPWDD;

Strategy 8.1

• The ECDMH and OPWDD Subcommittee will facilitate discussions pertaining to the development of training opportunities in an effort to support and assist individuals with Developmental Disabilities and their families to develop greater self-advocacy skills to prepare for managed care and system reform in the OPWDD service delivery structure.

Metric:
The OPWDD Subcommittee will plan for working with community stakeholders to develop training opportunities for families related to health care reforam and managed care; minimally we will request community stakeholders to report on the details of the trainings provided at bi-monthly subcommittee meetings.

Agency: OPWDD;